

National Quality Management Program (NQMP)

Measuring Tricare's Clinical Performance

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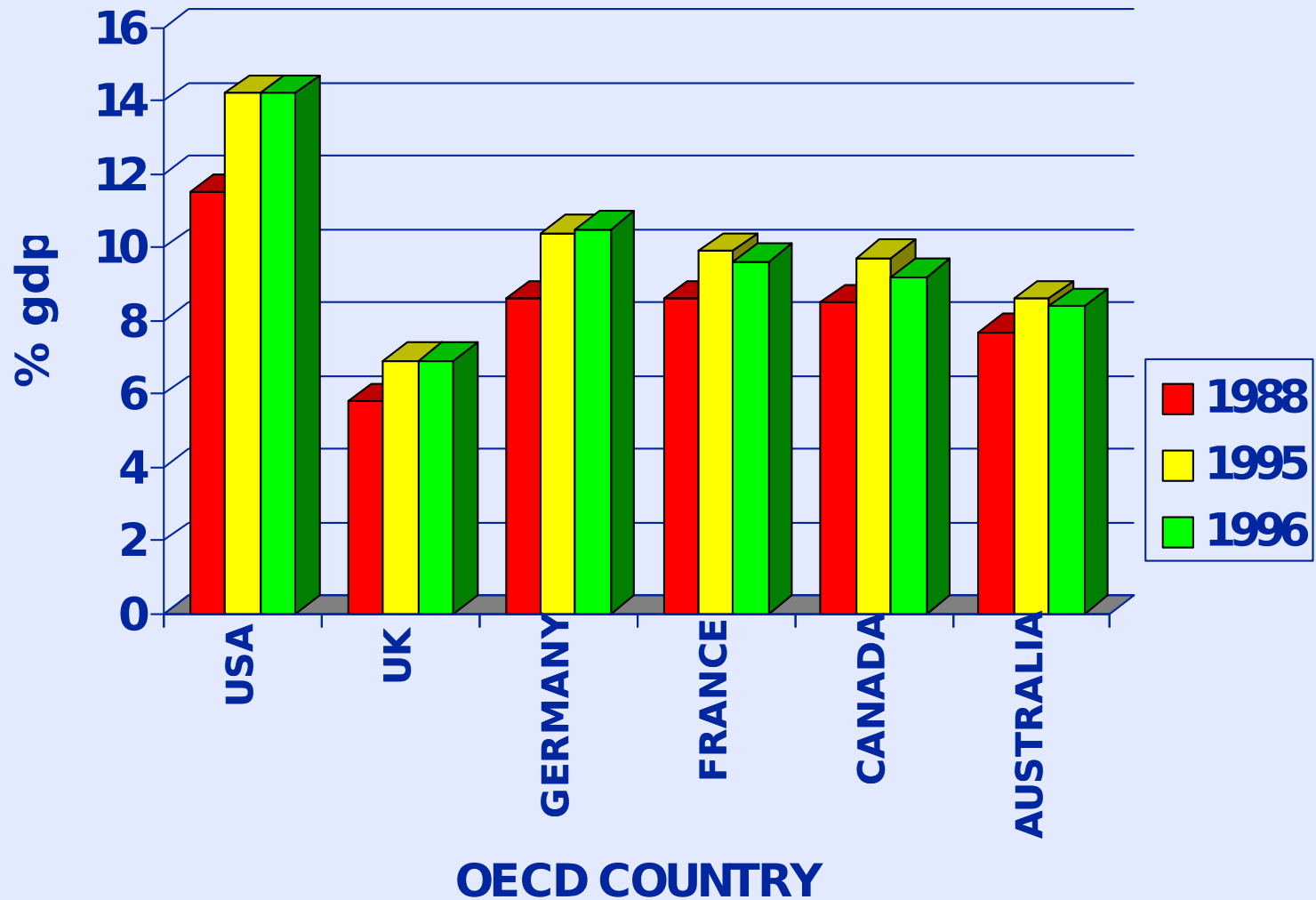


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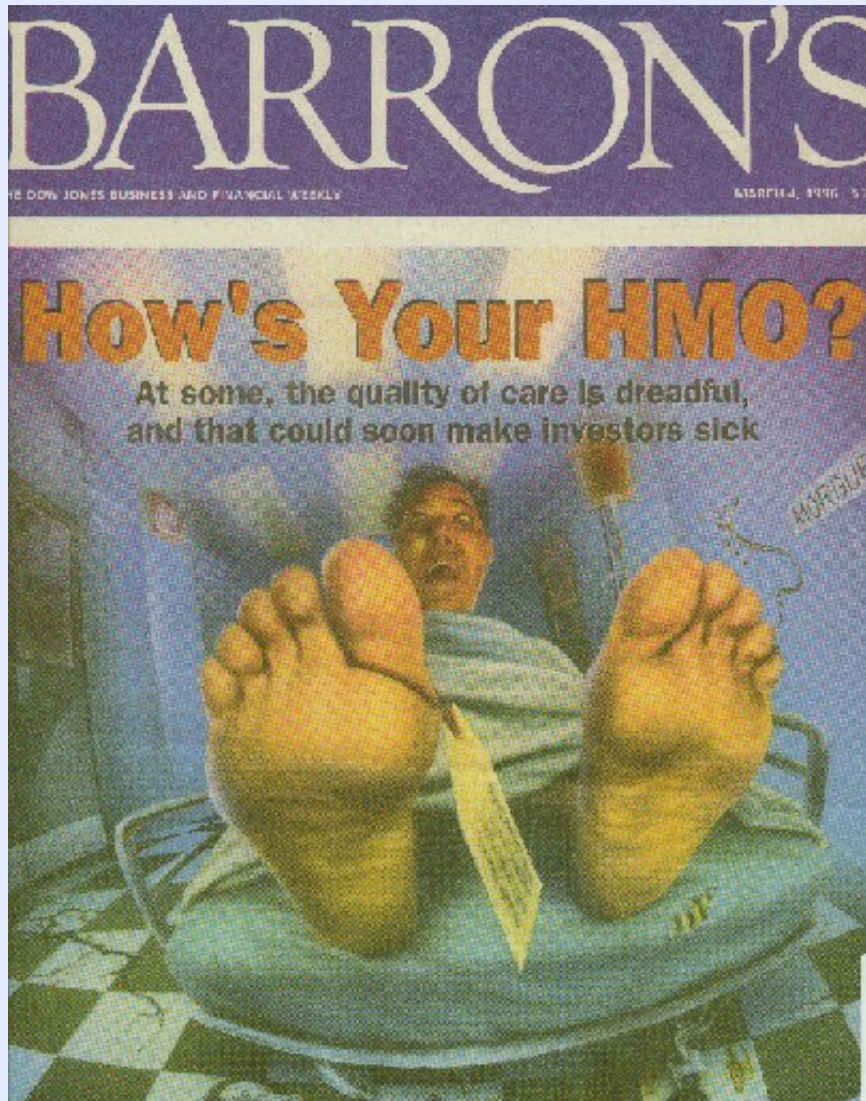
OBJECTIVES: National Quality Management Program: Clinical Evaluation Performance Reports

- Explain the purpose of the National Quality Management Program's focused studies.
- Identify the elements and methodology of Clinical Practice Profiles and Best Clinical Practice.
- Relate various means to employ the NQMP Quality Management Reviews results.
- Recognize importance of participating in the effort.

% GDP on Health Care



COSTS V QUALITY



. . . “Seven out of ten people agree that there are serious problems with the quality of health care and that the quality of care is often compromised to save money.”

“. . . Eight out of ten expressed a strong desire for better information about how to evaluate the quality of medical care.”

***- National Coalition on Health Care
Survey Highlights, January 23, 1997***

“As more employers bring costs under control, we expect them to turn their attention to getting better quality and value for their health care dollar.”

Mary Jane England, MD, President, WBGH Is Cost Everything? Getting Value for Your Health Care Dollar (a survey conducted by the Washington Business Group on Health and Watson Wyatt Worldwide, February 29, 1996)

“When negotiating for health care services, payers often have more information about a hospital’s performance -- right down to specific physicians -- than the hospital itself has. But I keep telling providers that we, as payers, don’t want to have to generate performance information on them. For the most part, we have access only to claims data. Only providers can generate fair, accurate, clinically oriented performance reports.”

Kenneth W. Gary, manager of compensation and benefits at Georgia Power Co. in Atlanta

American Medical News, April 8, 1996

“What we see now in the media, like in Barron’s (March 4, 1996), are attempts at comparisons made with inadequate data because I certainly couldn’t tell you the best five HMOs are in the United States, as far as quality is concerned.

You’re going to see story after story (in the media) comparing doctors. They don’t mean anything. We don’t have the means to do it . . . data can help consumers pick a sensible health plan.”

Paul Elwood, MD

Modern Healthcare, April 22, 1996, p. 33

“The most significant limitations in ‘America’s Best Hospitals’ reflect the astonishing paucity of data sources available for such research,” they said.

. . . “we are in total agreement that all Americans should have unshakable performance data in this vital area of their lives. The data available fall short of that standard because the health care industry has declined to develop them.”

-U.S. News reply to April 9, 1997 JAMA article critical

to “Americas Best Hospitals” review

***Washington Post Health Section
Tuesday, April 15, 1997***

THESE CONCERNS ARE NOT NEW...

“And if an ox gore a man or a woman that they die, the ox shall be surely stoned, and its flesh shall not be eaten; but the owner of the ox shall be quit.

But if the ox was wont to gore in time past, and warning hath been given to its owner, and he hath not kept in, but it hath killed a man or a woman; the ox shall be stoned and its owner also shall be put to death.”

The Cycle of Continuous Improvement



The Six Components of NQMP

- **Readiness**
- **Accreditation**
- **Credentialing and Privileging**
- **Licensure**
- **National Practitioner Data I**
- **External Review**



NQMP vs. Other Discharge Diagnosis-Based Evaluations

- **NQMP**
 - **Not Subject to Discharge Diagnosis Coding Errors or Biases**
 - **Focus on Processes of Care**
 - **Focus on Policies for Care**
 - **Links Policies and Processes to OUTCOMES**
 - **Risk-Adjust (to determine how well you play the hand, not what is dealt to you)**

NQMP

- **Evaluates Multiple Tricare Outcomes**
 - Financial (cost minimization)
 - Technical (which way is the “best” way)
 - Clinical (preventing morbidity and mortality)
 - Human (functional status and satisfaction)
- **Provides Information to Multiple Users: HA, Lead Agent, Service, Intermediate Command, MTFs**
- **MULTIPLE “CUSTOMERS” ADDRESSED WITH SINGLE EFFORT AIMED AT PATIENTS**

NQMP

- **Financial Outcomes**
 - **Reduce Costs and Live Within Capitation Rates**
 - **Reduce Malpractice Cases**
 - **Enhance UM Activities**
 - **Increased Return on Investment (ROI)**

NQMP

- **Technical Outcomes**
 - **Improve Efficiency of Care**
 - **Increase Treatment Facility Capacity**
 - **Enhance Care Innovation**
 - **Improve Management of Care**



NQMP

- **Clinical Outcomes**
 - **Increase Use of Appropriate Level and Setting of Care (UM)**
 - **Decrease Morbidity and Mortality**
 - **Decrease Treatment Errors**
 - **Increase Guideline Use and Development**

NQMP

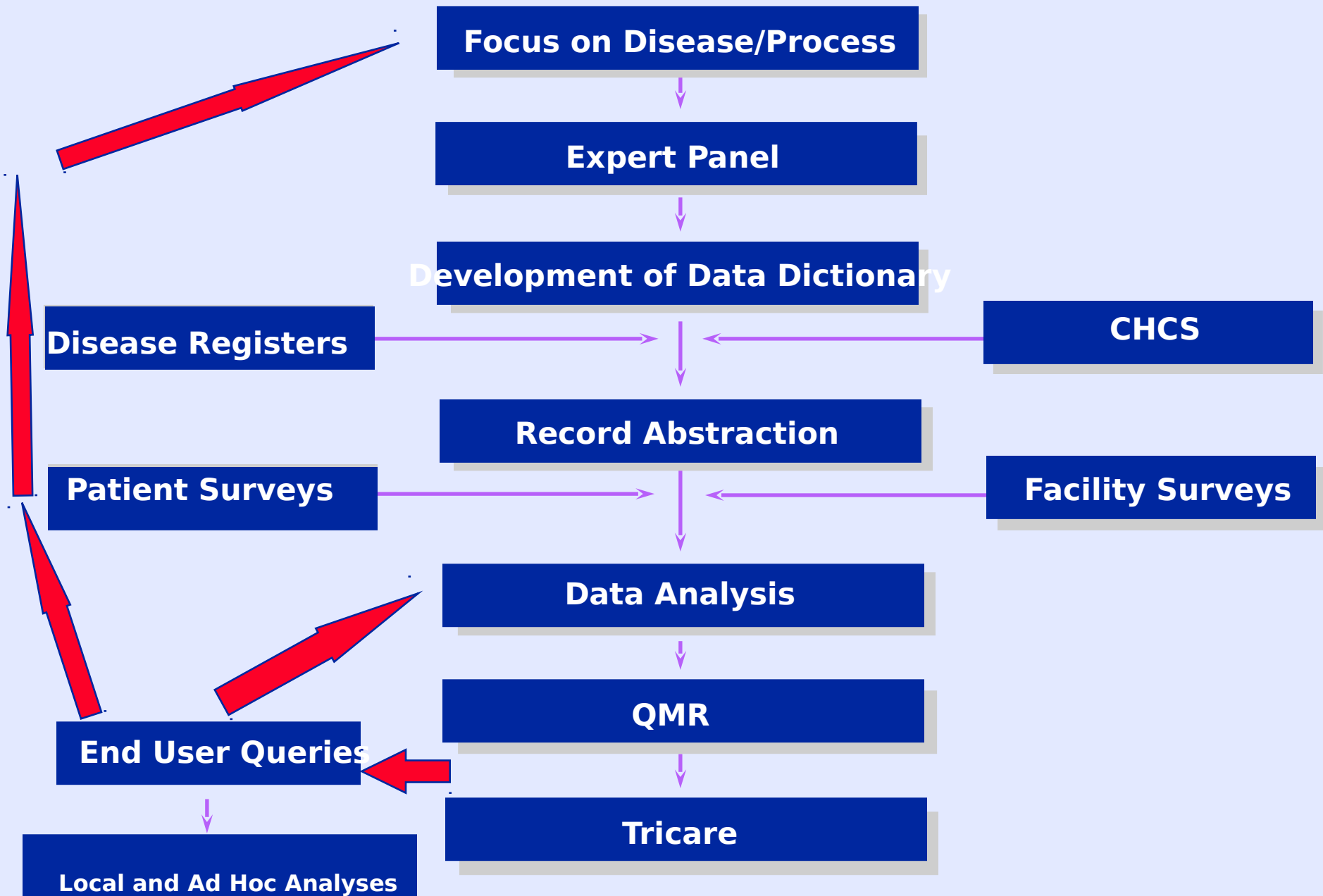
- **Human Outcomes**
 - **Increase Enrollee Satisfaction**
 - **Increase Enrollee Retention**
 - **Increase Provider Satisfaction**
 - **Improve Organizational Performance**
 - **Improve Functional Status of Enrollees**
 - **Enhance Marketing Efforts**
 - **Increase Educational Efforts**

Topics for Special Study

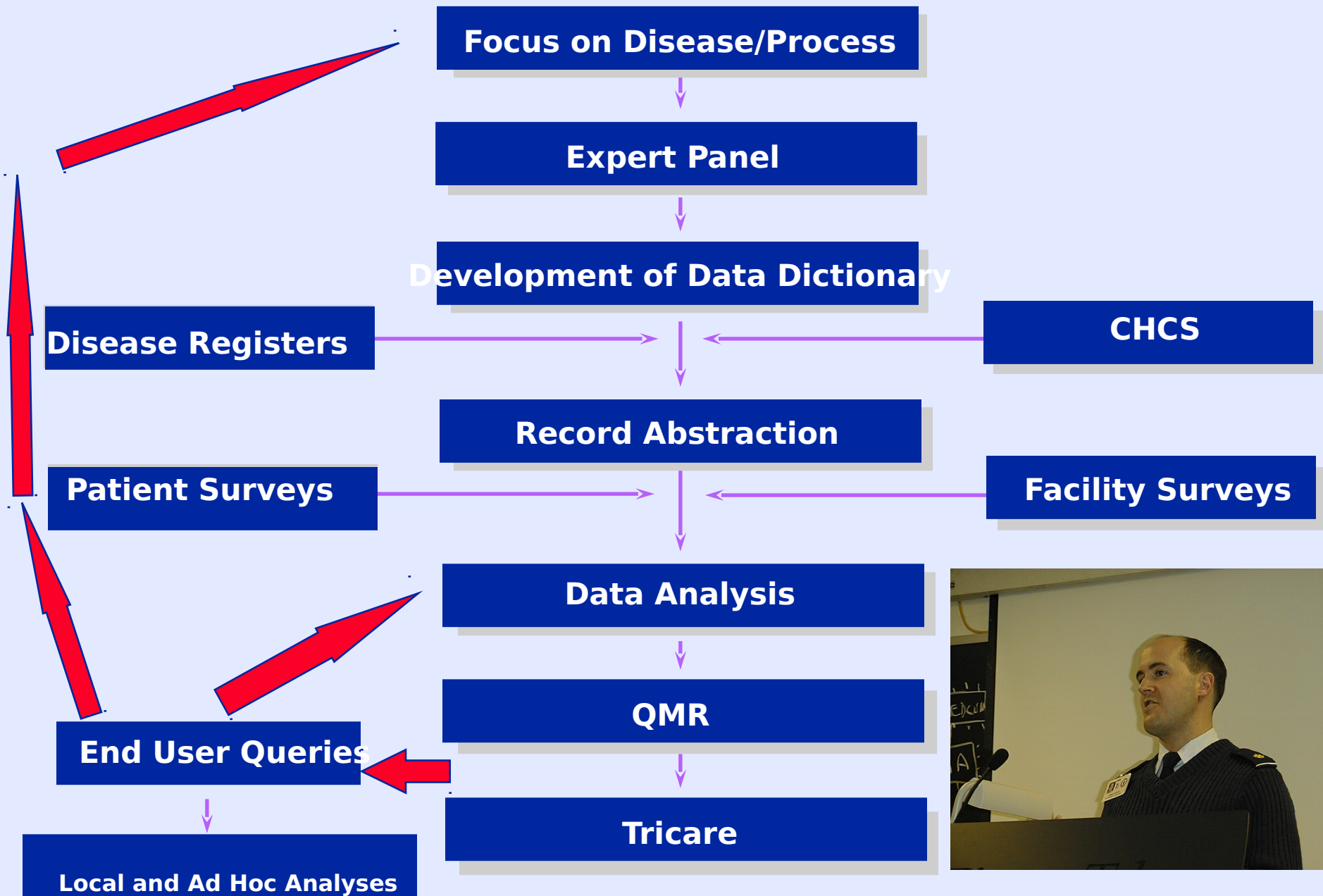
- **Obstetrics**
- **Cardiovascular Disease**
- **Orthopedics**
- **Diabetes**
- **Pediatric Asthma**
- **Mental Health**
- **Other *Ad Hoc* Specialty Areas**
Liver, GERD, Hernia)



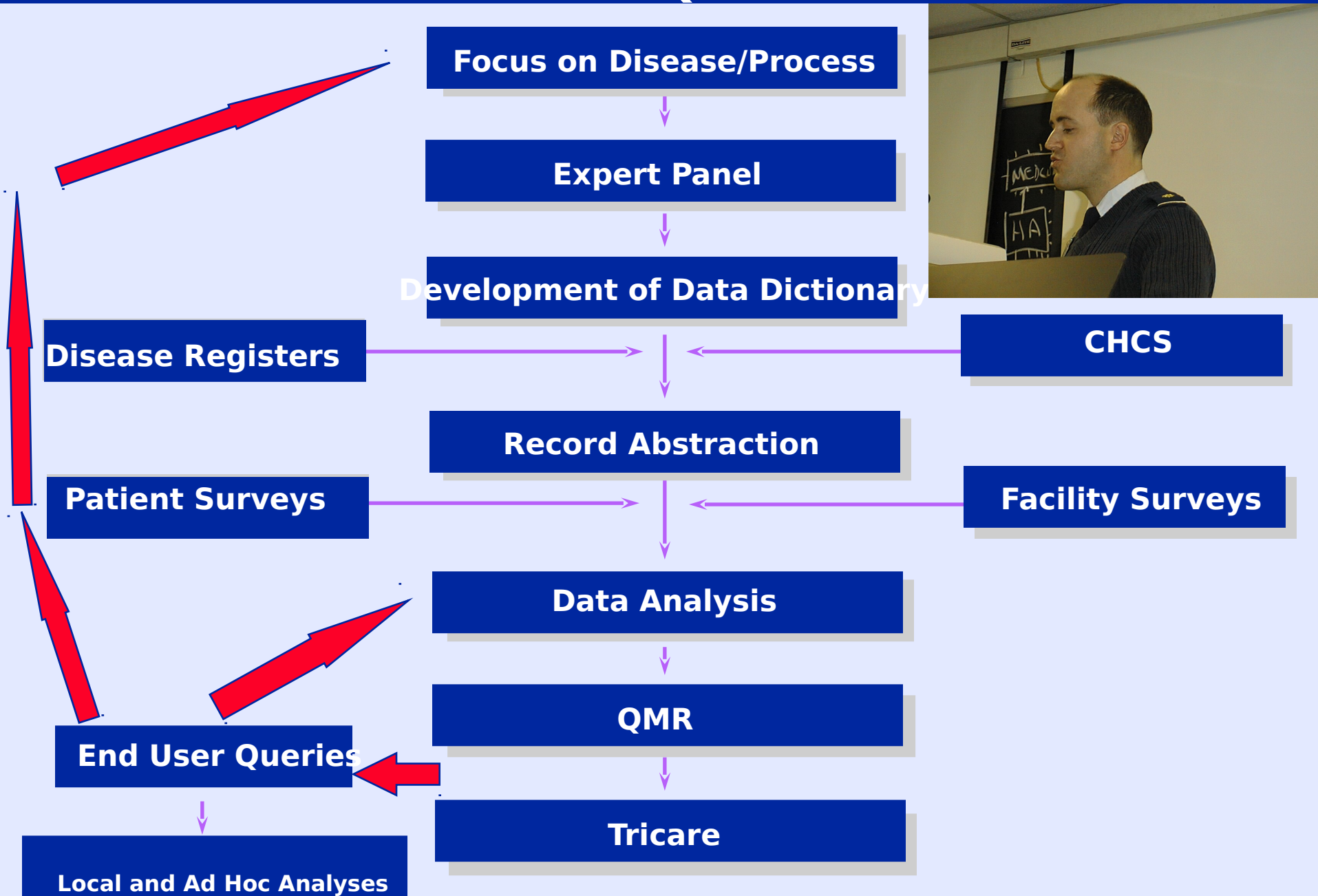
What is the NQMP Process?



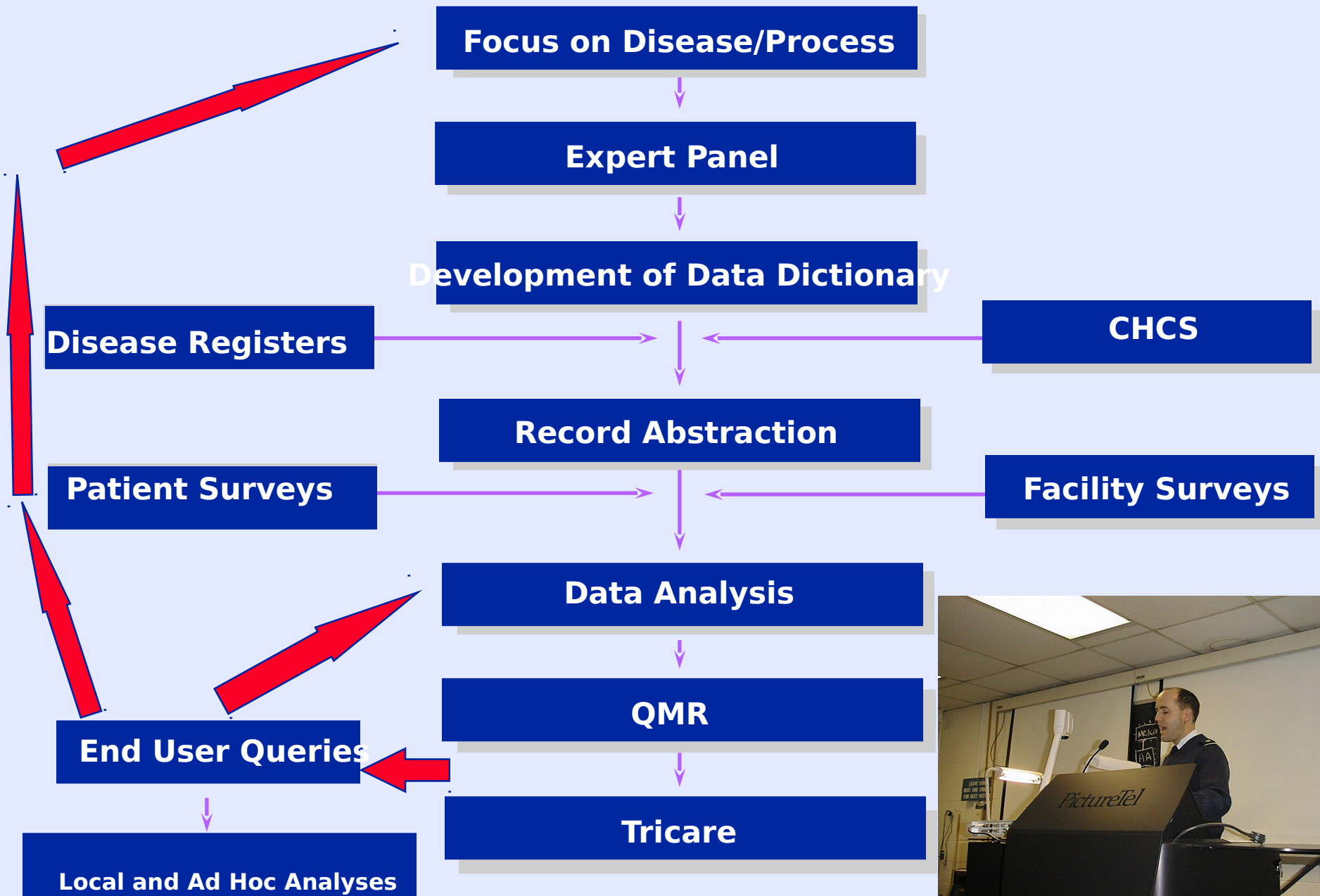
What is the NQMP Process?



What is the NQMP Process?



What is the NQMP Process?



THE OUTCOME - INTERVENTION RELATIONSHIP:

$$\text{OUTCOME} = f(\text{INTERVENTION}) + f(\text{PATIENT}) + \text{CHANCE}$$

- **THIS EXPLAINS WHY IT IS
SOMETIMES BETTER TO HAVE
A LUCKY DOCTOR THAN A
SMART DOCTOR!**

Definitions

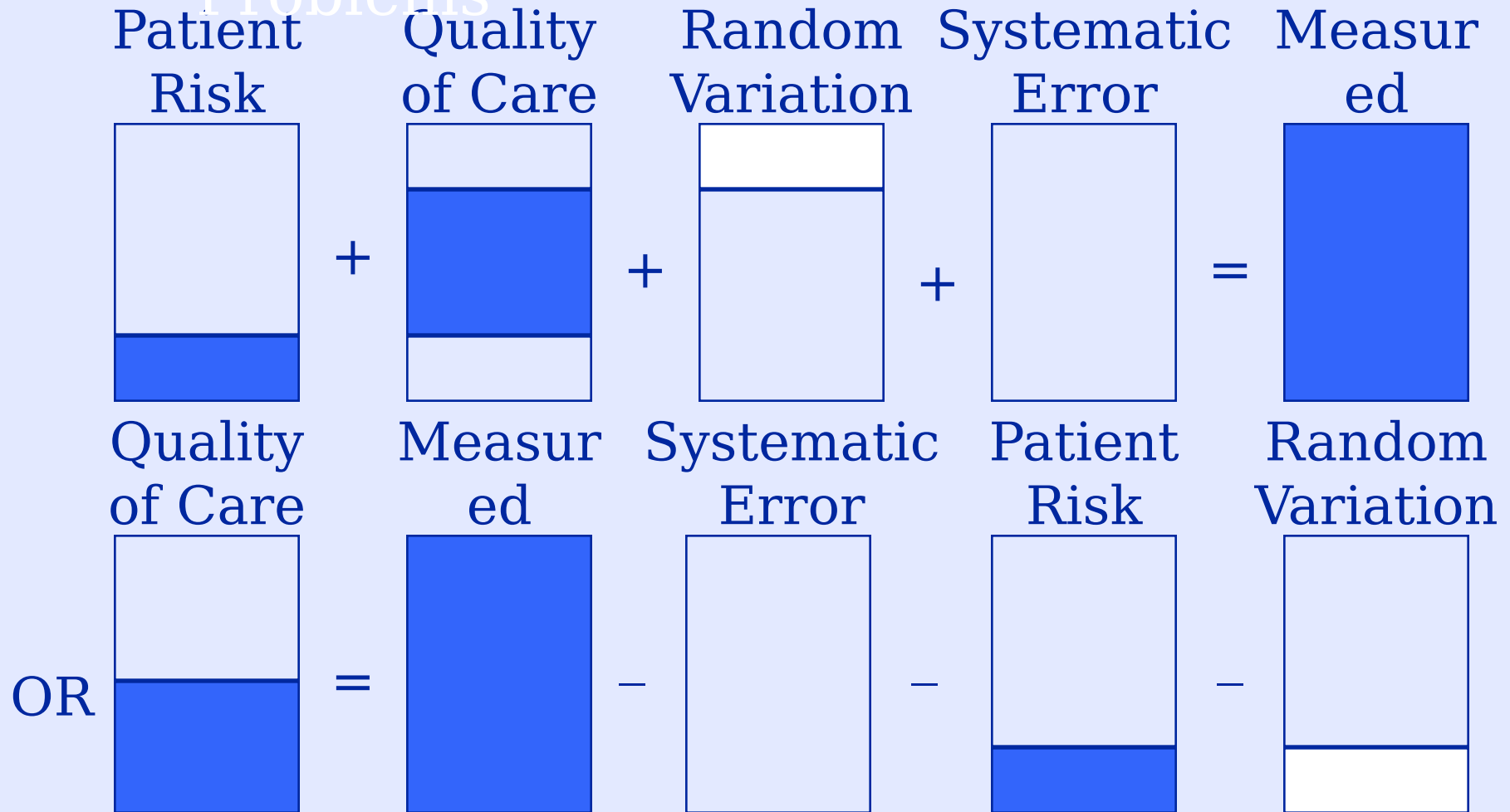
- Expected Value
 - the estimated of predicted value based on a model that uses patient and process inputs; can be personal intuition or analytical
- Observed Value
 - a measurement or count of an important outcome
- **OUTCOME = p(OUTCOME) + INTERVENTION + CHANCE**

DANGERS OF RESEARCH ON “QUALITY”

- Simple studies of interventions and outcomes may be misleading
 - MD Anderson or Dana-Farber Cancer Institute or WHMC v. community hospital
 - How good is “good enough”?

DOCTOR	TOTAL PATIENTS	ACTUAL DEATHS	EXPECTED DEATHS	STATISTICAL RATING
A	96	5	0 - 7	OK
B	103	11	0 - 8	YIKES!
C	88	7	0 - 6	NO GOOD
D	88	7	0 - 6	NO GOOD
E	67	10	1 - 8	YIKES!

Measuring Quality of Care: Ideals and Problems

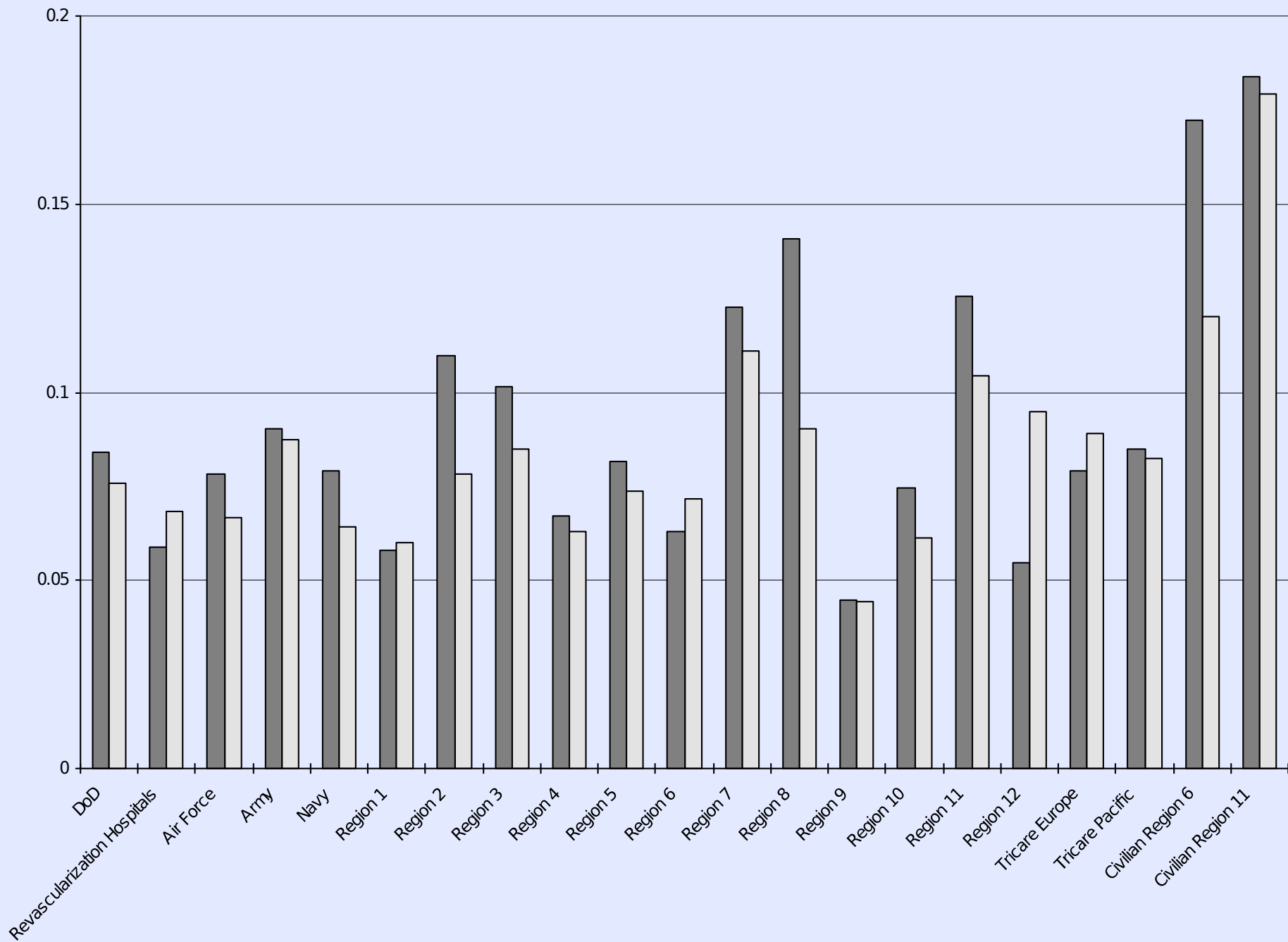


- **ANALYTIC TECHNIQUES AIM TO QUANTIFY PATIENT RISK, OVERWHELM RANDOM VARIATION WITH SAMPLE SIZE, AND LIMIT SYSTEMATIC ERROR THROUGH CAREFUL DATA COLLECTION AND ANALYSIS**

RISK ADJUSTERS

- DEMOGRAPHICS (age, gender, e
- SOCIOECONOMIC STATUS
- COMORBIDITIES
- FUNCTIONAL STATUS
- ADHERENCE TO TREATMENT
- PROVIDER AND FACILITY CHARACTERISTICS
- SPECIFIC FACTORS:
 - RISK FACTORS FOR POOR OUTCOME
 - DISEASE STAGE
 - PERFORMANCE STATUS





Clinical Practice Profile

DATA SOURCES

- Administrative
- Primary Clinical
- Organizational Survey
- Patient Survey

- Clinical Outcome
- Patient Perception
- Patient Functional Status

Clinical Practice Profile

=

**Patient Outcome
Cost**

- Resource Cost Unit
- Charges
- Costs

Best Clinical Practice

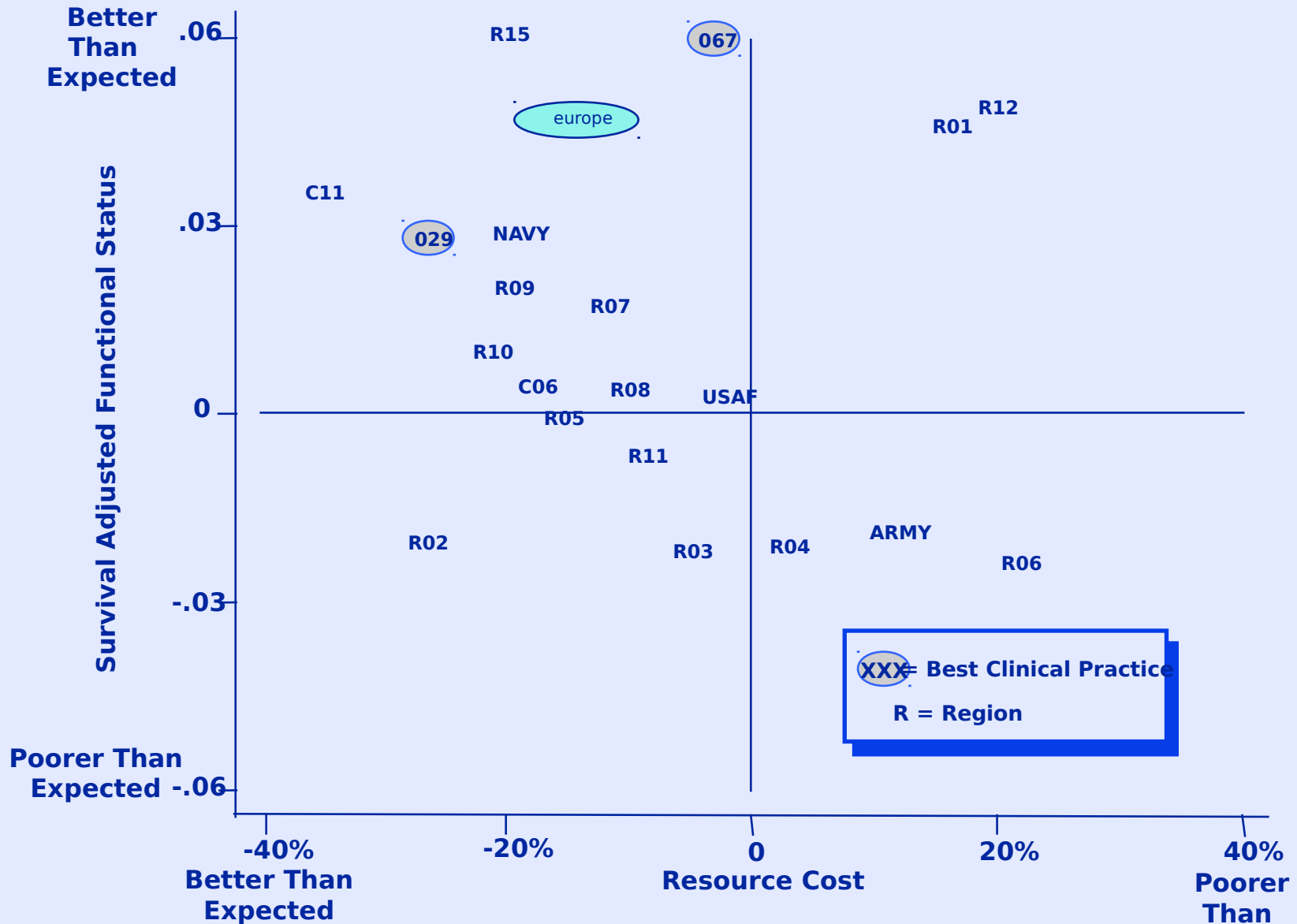
Best Clinical Practice = $\frac{\text{Best Outcomes}}{\text{Most Effective Use of Resources}}$

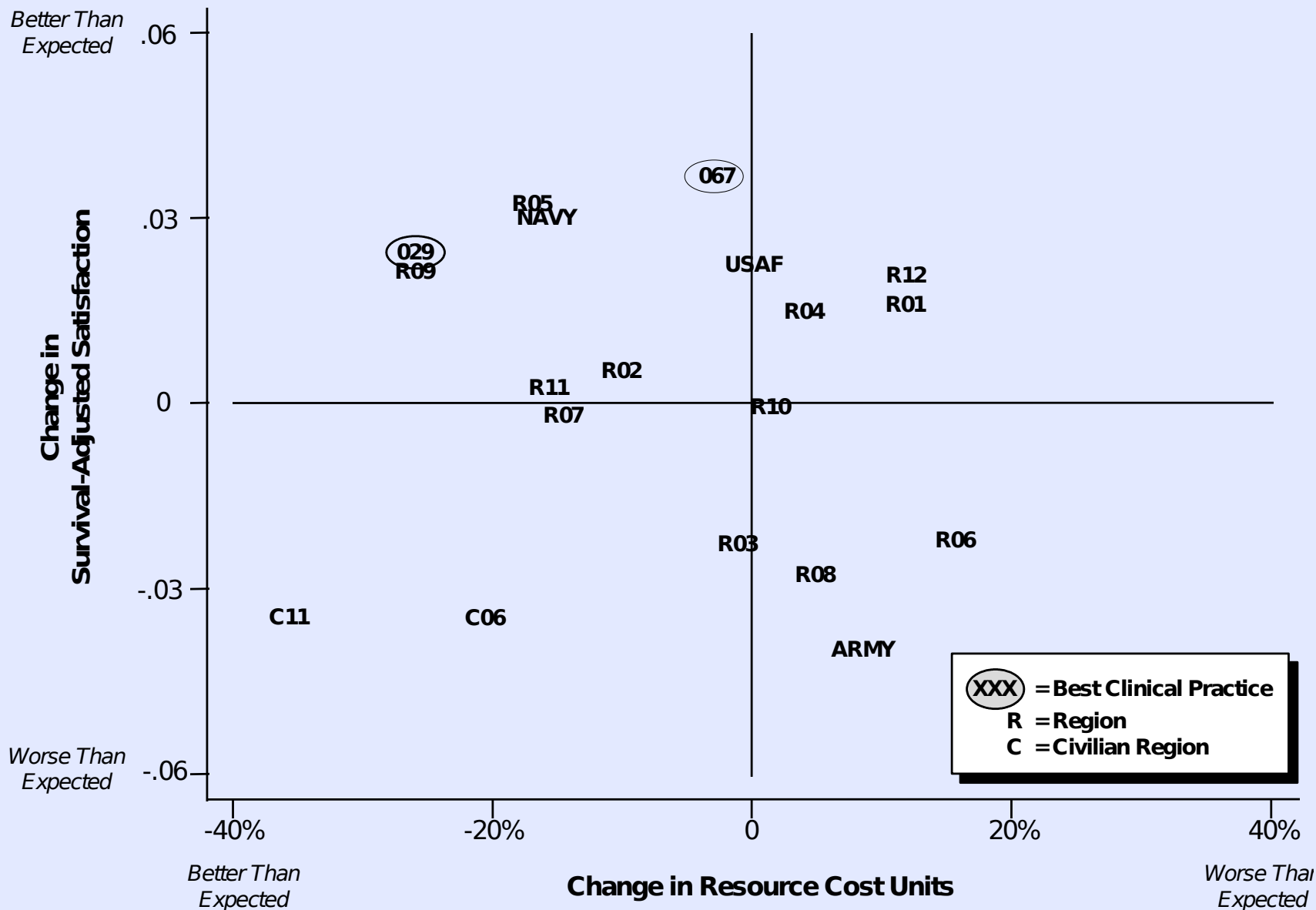
- WHERE YOU WANT TO BE:

GOAL: Quadrant 1 better than expected SAFS better than expected RCU	Quadrant 2 better than expected SAFS worse than expected RCU
Quadrant 4 worse than expected SAFS better than expected RCU	Quadrant 3 worse than expected SAFS worse than expected RCU

**NB: FOR SOMEONE TO BE IN QUADRANT 1
OTHERS WILL HAVE TO BE IN QUADRANTS 2,
3, AND 4**

- All Cases
- DoD





PATIENT SATISFACTION PROFILES

Good News

- **NQMP Special Studies Meet All ORYX Requirements And Were Formally Approved By The JCAHO.**



Better News

- **Health Topics Selected for NQMP Review in FY98 (With Addition of Gastrointestinal Conditions) Meet the JCAHO's 20% Requirement for ALL Inpatient MTFs.**



Best News

- **By Slightly Adjusting the NQMP Process, MTFs Can Meet ORYX Accreditation Requirements With *RELATIVELY LITTLE* Effort**
- **To be in compliance, however, MTFs must work with the results on a local level**

ORYX Process



***LOCAL
IMPLEMENTATION/ANALYSIS
EFFORT IS CRITICAL BETWEEN***

How to EmPLY the Results Locally

- APPLY CENTRALLY DEVELOPED RESULTS TO LOCAL TriCare GOALS**
- Reduce Malpractice Cases**
- Enhance UM Activities**
- Enhance Care Innovation**
- Improve Management of Care**
- Decrease Morbidity and Mortality**
- Decrease Treatment Errors**
- Increase Guideline Use and Development**

Implications of Clinical Support Tool

DoD - BPL - 96

Process	Frequencies (percent of deliveries)	
	Current	Projected
Total operative deliveries	29.3%	22.2%
All C-sections	16.8%	21.5%
Scheduled C-sections	5.5%	15.4%
Unscheduled C-sections	11.3%	6.1%
Operative vaginal deliveries	12.5%	0.7%

- Improvement in score per patient
0.26 (9%) -
- Cost reduction per patient \$264
- Total cost reduction \$16,000,000

Becoming A Part of the Process

- **Success / Value of the NQMP Is Dependent Upon Completion Of The Feedback Loops Built Into The Process**
- **Risk Adjustment Methodology is imperfect, but as good as it gets!**
- **The NQMP Process Requires Continuous Re-evaluation and IMPROVEMENT**
- **End-Users (Not Experts, Abstractors, Analysts, or Administrators) Are Essential To The EFFORT**





VSP

- Evaluates Multiple Telecom Solutions
 - Financial (price/performance)
 - Technical (effect size to the "best" tool)
 - Clinical (demonstrating methods and results)
 - Human (functional value and satisfaction)
- Provides Information to Multiple Users (in, out, and across)
- Agent, Service, Intermediate, Content, and Multiple "CUSTOMERS" ADDRESSING WITH SINGLE OFFICE AND/OR PERSON

PictureTel







Winning the Managed Care Game

Web Address:

<http://cim.usuhs.mil/pmbgr/schedule.htm>

e-mail Address:

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